State of Connecticut
Regulation of
Insurance Department
Concerning
Health Insurance Rate and Form Filings

Section 38a-481-1 of the Regulations of Connecticut State Agencies is amended to read as follows:

Sec. 38a-481-1. Definitions

As used in Sections 38a-481-1 to 38a-481-[4] 9, inclusive, of the Regulations of Connecticut State Agencies, unless the context otherwise requires:

[(a)**]**(1) ''Commissioner'' means the Insurance Commissioner of the State of Connecticut.

(2) "Department" means the Connecticut Insurance Department

(3) "Excessive Rate" means the rate is unreasonably high for the insurance provided.

(4) "Experience Period" means the most recent twelve-month period from which the insurer accumulates the data to support a rate filing.

[(b)**]**(5) ''Form'' means a policy of insurance against loss or expense from sickness, or from bodily injury or death by accident, or application, rider or endorsement used in connection therewith.

(6) "Inadequate Rate" means a rate that is unreasonably low for the insurance provided, and continued use of it would endanger solvency of the insurer.

[(c)**]**(7) ''Insurer'' means an insurance company licensed by the Commissioner to write accident and health insurance.

(8) "Loss ratio" has the same meaning as provided in Section 38a-481(a) of the Connecticut General Statutes.

(9) "PPACA" means Patient Protection and Affordable Care Act, P.L. 111-148, as amended from time to time, and regulations adopted thereunder.

[(d)**]**(10) "SERFF" means the National Association of Insurance **[**Commissioners**]**Commissioners' System for Electronic Rate and Form Filing.

(11) "Unfairly Discriminatory" means rating practices that reflect differences based on age, disability, race, ethnicity, gender, sexual orientation or health status that are not actuarially justified or otherwise prohibited by law.

(12) "Utilization data" means the number of services used by a fixed number of covered persons, as defined 38a-591a(13), over a fixed length of time.

The Regulations of Connecticut State Agencies are amended by adding sections 38a-481-5 to 38a-481-9, inclusive, as follows:

(NEW) Sec. 38a-481-5. Timing for rate filings

(a) Rate filings shall be made no later than ninety (90) days prior to the date an insurer intends to market such plans.

(b) For plans subject to the requirements of the PPACA, rate filings shall be filed annually no later than a date prescribed by the Commissioner. The Commissioner shall provide notice to insurers

no later than thirty (30) days prior to the prescribed date each year.

(NEW) Sec. 38a-481-6. Transparency of rate filings

The information supplied to the Department to fulfill its statutory rate review requirement is not confidential. Complete rate filings including all correspondence and documentation are available through SERFF and may be posted on the Department website for review and comment by the public. All public comments shall be reviewed by the Department and considered as an additional element of the review determination.

(NEW) Sec. 38a-481-7. Rate filing process

(a) All rate filings shall be submitted via SERFF.

(b) For filings subject to the requirements of the PPACA, all fields in SERFF added for reporting requirements to the federal Department of Health and Human Services in accordance with PPACA shall be populated.

(c) All rate filings shall be made in accordance with Department bulletins, notifications, and other written guidance.

(d) Incomplete submissions may be rejected.

(e) No rate filing shall be approved if the Department determines that it is excessive, inadequate or unfairly discriminatory.

(f) Rates shall not be approved unless the policy forms to which they apply are approved.

(g) No rate may be marketed until the rates are approved. The Commissioner may grant conditional approval to enhance the fairness and efficiency of the marketplace.

(NEW) Sec. 38a-481-8. Minimum rate filing requirements

(a) All rate filings shall include, at a minimum, the following:

(1) A cover letter describing all policy forms affected by the requested rates or rate changes as well as the effective date of the requested rates or rate changes.

(2) The detailed development for the initial rate or rate increase.

(3) Historical experience from inception-to-date including earned premium, paid claims, incurred claims, membership, actual loss ratios and expected loss ratios.

(A) Both state-specific and nationwide experience shall be provided.

(B) Annual experience shall be provided for all years.

(4) A certification by a member of the American Academy of Actuaries that the rate filing is in compliance with this section. Such certification shall include a statement by a member of the American Academy of Actuaries that the rates are reasonable in relation to the benefits provided, and that they are not excessive, inadequate or unfairly discriminatory.

(5) Claim lag triangles.

(6) Cost for each newly mandated benefit that applies to the type of insurance for which the rate filing has been submitted.

(7) Any additional information the Commissioner deems necessary to review the rate filing.

(b) Any changes submitted after the initial rate filing shall include a version that shows the changes made as well as a clean copy to facilitate the Department’s review.

(c) When the information required under subsection (a) of this section is received, actuarial review shall commence. Rate filings shall be reviewed in the order received by the Department.

(NEW) Sec. 38a-481-9. Additional rate filing requirements

(a) All rate filings for individual health insurance providing coverage of the types specified in

Connecticut General Statutes Section 38a-469 (1), (2), (4), (11) and (12) shall include:

(1) A demonstration that the experience data submitted is consistent with the most recent financial statement filed by the insurer with the Department pursuant to section 38a-53a of the Connecticut General Statutes.

(2) Utilization trend by broad service category, including utilization data.

(3) Impact of cost sharing leverage on trend.

(4) Medical technology trend.

(5) Benefit buy-down analysis and impact on trend.

(6) Cost of each new benefit mandate or requirement due to a change in state or federal law, separately identified, from the experience period to the rating period.

(7) Unit cost trend by broad service category, including actual unit cost data and impact of provider contract changes from experience period to rating period (medical and prescription drug separately).

(8) An annual certification of compliance with mental health parity. For plans that have a copayment for a mental health office visit set at the specialist level, a demonstration that the copayment is in compliance with mental health parity shall also be filed.

(9) A certification and demonstration that any substitution of a non-dollar limit on an essential health benefit as permitted by the PPACA is actuarially justified.

(10) A comparison of the proposed retention charge in the filing to the most recently filed financial statement for the health care center or insurance company for which this filing is being made.

(11) Monthly historical experience including earned premium, paid claims, incurred claims, membership, actual loss ratios and expected loss ratios shall be provided for the most recent two (2) years.

(12) The current capital and surplus for the health care center or insurance company for which this filing is being made.

(13) For filings subject to the PPACA, a demonstration that the rate increase requested in this filing will generate an expected medical loss ratio, for rebate purposes, that is consistent with the medical loss ratio prescribed by the federal law for individual health insurance.

(14) For filings subject to the PPACA, the Uniform Rate Review Template (URRT), the Part III Actuarial Memorandum, and the Health Insurance Oversight System rate tables. The Health Insurance Oversight System rate tables shall be filed in a portable document format. Insurers shall also provide a summary of benefits for each plan design along with the federal Department of Health and Human Services' Actuarial Value Calculator output that confirms compliance with the corresponding metal tier set forth in the PPACA. The Health Insurance Oversight System plan ID and the corresponding plan name on the summary of benefits for each plan shall be indicated.

(b) Every rate filing submission for individual health insurance providing coverage of the types specified in Connecticut General Statutes Section 38a-469 (1), (2), (4), (11) and (12) that includes an increase to previously approved rates shall include a summary of the rate increases requested and shall be clearly marked as Appendix A. The appendix shall include, but not be limited to, the following:

(1) The requested rate increase for each product contained within the rate filing and the effective date of each proposed rate increase. The requested increase for each product shall be identified as a specific percent increase or, if appropriate, a range of percent increases with an explanation of what the variance is that produces the range.

(2) Number of covered individuals for each product; number of covered policyholders; minimum current premium on a per member per month (pmpm) basis; minimum proposed premium on a pmpm basis; maximum current premium on a pmpm basis; maximum proposed premium on a pmpm basis

and the percentage change.

(3) Each component of the rate increase including trend, experience adjustments and any other factors that are a component of the requested rate increase. These may be identified as a specific percent or, if appropriate, a percent range.

(4) A footnote listing any other factors that can have an impact on premium rates that have not been specifically identified in the appendix, including, but not limited to, age bands, gender, geographic area, and smoking.

Statement of Purpose: CGS § 38a-481(a) and CGS §38a-481(b) require that regulations pertaining to filing procedures for individual health insurance rates shall be adopted by the Commissioner and that the Commissioner shall adopt a regulation to prescribe standards to ensure that rates are not excessive, inadequate, or unfairly discriminatory. All amendments reflect updates to existing regulations to conform to the current statutes and requirements.

The revisions are being made as a result of the requirements in CGS § 38a-481(a) and CGS §38a-481(b). All updates to existing regulations contained herein are to conform to the current state and federal statutes, including the Affordable Care Act. The updates include changes to codify the Department's rate review process in regulation for individual health insurance to ensure that rates are not excessive, inadequate or unfairly discriminatory. The updates provide definitions for rate filing and provide requirements for filing of individual health insurance rates. As required by Conn. Gen. Stat. § 4-l68a, the Insurance Department considered the impact of the proposed amended regulations on small business, and in doing so, determined that the preparation of a regulatory flexibility analysis, as contemplated by this statute, was not needed. The amendments reflect activities to be undertaken by insurance companies offering health insurance products which are not small businesses.

Explanation for Re-submittal to AG and LRRC

These regulations are being resubmitted under CGS § 4-170(e) to the Attorney General's office after being rejected without prejudice from the regulation review committee because they required substantive edits. The Department made all substantive and all but one of the technical corrections requested in the LCO memo including changing the definition of "unfairly discriminatory" to the definition used by the federal government in determining rates. All other provisions of these regulations remain unchanged. The Department declined to make technical correction #3 in the LCO memo that requested we change the definition of "experience period" to "experience". The Department declined to make this change because the two terms are actuarial terms of art and are separate things.